DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-3141

June 9, 1983

ALL-COUNTY LETTER NO. 83-51

TO: ALL-COUNTY WELFARE DIRECTORS

SUBJECT: NOTICE OF ACTION LANGUAGE FOR UNACCOMPANIED REFUGEE AND ENTRANT MINORS
REFERENCE: ACL 83-23

This letter is to remind CWDs that are affected by All-County Letter 83-23 (Unaccompanied Refugee and Entrant Minors), that a Notice of Action must be issued preceding any changes to the recipient's grant or status as provided by EAS Sections 22-021 and 22-022.

Attached are two suggested samples of Notices (to be forwarded to RCA-FC/ECA-FC recipients respectively) that may be used to inform affected aid recipients of changes in their aid status. You may wish to devise appropriate language for notification to fit special case situations in your county.

If you have any questions, please call your Office of Refugee Services (ORS) CWD Operations Consultant at (916) 322-3141, or (415) 557-8588, as appropriate.

JOHN J. QAISSA
Chief Deputy Director

Attachments

NOTICE OF ACTION

Your monthly aid payment and Medi-Cal benefits received under the Refugee Cash Assistance -Foster Care (RCA-FC) Program will be discontinued effective _____.

REASON:

You were incorrectly classified as a Refugee Unaccompanied Minor and are therefore not eligible for the RCA-FC monthly benefits you now receive. You must qualify as a Refugee Unaccompanied Minor in order to receive RCA-FC benefits.

You do not qualify because:

☐ You are 18 years old and are not expected to complete high school or vocational training before your 19th birthday.

☐ You entered the U.S. accompanied by a parent or one of the following adult relatives: stepparent, sibling, or a stepbrother, stepsister, half brother, half sister, uncle, aunt, first cousin, nephew, niece, great or great-great grandparents, or the adult spouse of any such person; or an adult who had documentable evidence of legal custody of you. His/her name is _____.

☐ You have a parent or an above-listed relative in the U.S. His/her name is _____.

Even though you have been determined not to be eligible for RCA-FC, you may be eligible for other public assistance. Please contact this office at _____ if you need further information.

If you wish to apply for Medi-Cal, please contact _____.

AUTHORITY REQUIRING THIS ACTION

Refugee Act of 1980 (Public Law 96-212,Section 412)

ORR Action Transmittal 79-04

State Plan for Refugee Assistance and Services, Federal Fiscal Year 1983

NOTICE OF ACTION

Your monthly aid payment and Medi-Cal benefits received under the Entrant Cash Assistance -Foster Care (ECA-FC) Program will be discontinued effective _____ _____.

REASON:

You were incorrectly classified as a Cuban/Haitian Entrant Unaccompanied Minor and are therefore not eligible for the ECA-FC monthly benefits you now receive. You must qualify as a Cuban/Haitian Unaccompanied Minor in order to receive ECA-FC benefits.

You do not qualify because:

☐ You are 18 years old and are not expected to complete high school or vocational training before your 19th birthday.

☐ You entered the U.S. accompanied by a parent, or one of the following adult relatives: grandparent, aunt, uncle, sibling or an adult who had documentable evidence of legal custody of you. His/her name is _____.

☐ You have a parent in the U.S. His/her name is _____.

Even though you have been determined not to be eligible for ECA-FC, you may be eligible for other public assistance. Please contact this office at _____ if you need further information.

If you wish to apply for Medi-Cal, please contact _____

AUTHORITY REQUIRING THIS ACTION

Refugee Act of 1980 (Public Law 96-212, Section 412)

Refugee Education Assistance Act of 1980 (Public Law 96-422, Section 501)

ORR Action Transmittal 80-07

State Plan for Refugee Assistance and Services, Federal Fiscal Year 1983

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.

FOOD STAMPS† AND CASH GRANT: If this action stops or reduces your food stamps or cash grant and you ask for a hearing before the effective date of the action, your benefits may continue unchanged under certain circumstances until the hearing or until you receive your hearing decision. Food Stamps will not continue past the end of your current certification period.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

For the Deaf Only* TDD (800) 952-8349

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to my family's: ☐ Cash Grant ☐ Food Stamps ☐ Medi-Cal

Reasons for my request:

☐ I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

†**Food Stamps**: If any portion of food stamps provided to you while awaiting the hearing decision is determined to be an overissuance, the county may recover the value of the overissuance. If you want to avoid the possibility of such an overissuance, you may check the box below:

☐ I want my food stamps terminated or reduced to the new amount determined by the county until the hearing decision. If the hearing decision is in my favor, the county will make up the food stamps I lose as a result of checking this box.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, or the U.S. Department of Agriculture. Authority: W&IC 10950.